
CHAPTER VI. TARGET ELIGIBILITY TOWARD THE MOST NEEDY

In the past, changes in Medicaid eligibility have usually been formulated to close gaps in coverage rather than to reduce program costs. Faced with increasing costs and diminishing revenues during economic downturns, states have been reluctant to tighten eligibility standards. In today's economic climate, however, outlays could be trimmed either by curtailing coverage of the less needy or by targeting aid more precisely on the neediest.

MANDATE COVERAGE OF ALL CHILDREN IN LOW-INCOME FAMILIES

One approach would require states to extend Medicaid coverage to all children in low-income families--those, for example, in families with incomes below state AFDC income eligibility standards. At present, states have the option of covering low-income children in families that are not receiving AFDC benefits, and most have chosen to cover some such children; but only about one-third of the states have chosen to cover them all.¹ This approach, consistent with welfare's traditional orientation toward children, would produce more uniformity among state Medicaid programs. It would, however, raise program costs at both the state and local levels. An additional 4.7 million children under age 21 would become eligible for Medicaid in 1982. Federal outlays would be about \$100 million higher than at present, and state expenditures about \$80 million higher.²

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1. This expansion of eligibility to all "financially eligible" children differs from proposals for a Child Health Assurance Program (CHAP), which included a minimum national income eligibility standard. For example, the House version of CHAP, contained in H.R. 4962, would have established a minimum income eligibility standard of two-thirds of the federal poverty level.
 2. This estimate assumes a low rate of participation in the Medicaid program (about 12 percent) for these newly eligible children.

Although some of the flexibility states now enjoy in administering Medicaid would be lost, some state-to-state differences in eligibility for children would persist. Varying state AFDC standards would be used to determine eligibility for these children.

MANDATE COVERAGE OF THE MEDICALLY NEEDY

Mandating coverage for all the medically needy--the aged, blind, and disabled, and members of low-income families with dependent children--would affect the Medicaid programs of the 20 states that do not now cover this category of persons.³ The affected states would not be required to provide nursing home care to those qualifying as medically needy.

In the example examined here, states would use their existing AFDC income standards in determining Medicaid eligibility. States could be allowed to set an income standard for the medically needy at a level above their current income-assistance standards; however, many of the states that have chosen not to offer medically needy benefits under current law probably would not do so.

Under this option, federal costs in 1982 would rise by nearly \$700 million (excluding the costs of long-term care). The additional costs to states would be about \$500 million. As under the previous option, state discretion and state-to-state variation would decrease somewhat. But the income levels at which families could qualify for Medicaid would continue to be quite different among the states.

This option would ease access to health care for low-income people with low or moderate levels of medical expenses who are now likely to be deterred from the use of care by its cost. It would

3. The states that do not now provide coverage for the medically needy are Alabama, Alaska, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Mississippi, Missouri, Nevada, New Jersey, New Mexico, Ohio, Oregon, South Carolina, South Dakota, Texas, and Wyoming.

also provide financial relief to facilities that care for low-income patients with large medical expenses but who have been unable to pay their bills. The effects on health-care resources would be mixed. This option would give some financial relief to other third-party payers and to some public hospitals that now care for low-income patients whose unpaid bills are finally written off as bad debts.

In states now without coverage for the medically needy, the working poor are subject to loss of Medicaid, as well as cash assistance, when their incomes exceed the states' standards. Some critics have suggested that the so-called "Medicaid notch" serves as a work disincentive in states without coverage for the medically needy.⁴ Mandatory coverage for the medically needy would somewhat offset this drawback, because low-income people could continue to work and yet qualify for Medicaid if their incomes, after deducting medical expenses, fell below state standards.

TERMINATE CERTAIN OPTIONAL ELIGIBILITY CATEGORIES

Better targeting of benefits could be achieved by terminating eligibility for some people now entitled to Medicaid. One group that might be considered for termination consists of the elderly, blind, and disabled persons who receive cash assistance from state programs that supplement federal SSI benefits even though their incomes exceed the federal eligibility levels for SSI. Today, three-quarters of the states provide optional supplements, and almost all of them have chosen to provide Medicaid to people who receive only the state supplement to SSI.

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4. See, for example, Theodore R. Marmor, "Public Medical Assistance Programs and Cash Assistance: The Problems of Program Administration," in Integrating Income Maintenance Programs, edited by Irene Lurie, Academic Press, 1975. Marmor notes that, even in states with medically needy programs, the tax rate on Medicaid benefits is high. Increases in cash income raise the amount of medical expenses that an individual must incur in order to spend down to eligibility by \$1. Families with expected medical expenses less than the difference between the level of protected income and their own income may be discouraged from use of routine medical services.

If recipients of only the SSI supplemental payments were no longer eligible for Medicaid, federal expenditures could be reduced by about \$300 million in 1982 and, over five years, the savings could exceed \$1.9 billion.

This option could reduce or eliminate Medicaid benefits for about 600,000 people; however, many could qualify as medically needy. Most of the persons whose eligibility would terminate under this proposal now live in states with Medicaid coverage for the medically needy, so if they were to incur substantial medical expenses, they would continue to receive some benefits from Medicaid, although less than they do now. On the other hand, most of those who would lose automatic eligibility have relatively low incomes. Even in the states with coverage for the medically needy, this option could deter some from seeking needed care.

Eliminating Medicaid coverage for persons receiving only state supplemental SSI payments would lead to more uniform treatment of residents of different states. Currently, the aged, blind, and disabled with incomes similar to recipients of only the optional supplement to SSI, but residing in states that do not cover this group, may be unable to qualify for Medicaid.

REQUIRE RELATIVES TO ASSUME SOME FINANCIAL RESPONSIBILITY

The eligibility criteria of the SSI program make it possible for members of families with substantial income to qualify for Medicaid. Most states cannot require relatives of potential SSI recipients to assume financial responsibility for nursing home care. Generally, after a disabled or elderly person has been institutionalized for a certain period, the income of a parent or a spouse is not considered in determining eligibility for SSI. Fifteen states do not automatically grant Medicaid eligibility to SSI recipients, and some of these states impose a requirement that relatives be financially responsible to some extent when determining Medicaid eligibility for SSI recipients.⁵

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5. The 15 states are the so-called "209(b)" states that were permitted to retain more restrictive Medicaid eligibility criteria when SSI was created.

Requiring relatives to take financial responsibility for these costs could reduce federal and state expenditures for institutionalized people. Although such long-term care expenses are known to have made up 42 percent of all Medicaid-financed care in 1978, estimating the savings that could accrue from requiring some degree of financial responsibility by relatives is difficult because of limited national data.

A provision that relatives share financial responsibility for the care of institutionalized patients would be quite controversial. From the standpoint of program cost containment, it would have the clear advantage of discouraging families from institutionalizing chronically ill or disabled relatives, because the Medicaid assistance that now covers such care would be unavailable. On the other hand, home care, though it might be some families' preference, can be strenuous and very costly--beyond the means of many low-income families.

In the case of the elderly, the issue is particularly problematic. Nine out of 10 old people now institutionalized are single, and their financially responsible relatives would have to be their adult children. This raises questions of definition and responsibility. Are only biologically related children responsible for their parents? Should step-children be held responsible? Should children be required to support their biological parents, even in instances in which these parents provided little or no support to their children?

REQUIRE STATES TO ADOPT MINIMUM ELIGIBILITY STANDARDS

At some cost in state discretion, a set of uniform eligibility criteria could be established by the Congress to broaden Medicaid's coverage of the poor. This option would entail quite extensive revision of current eligibility standards. In the example examined here, all states could be required to grant Medicaid eligibility to all members of families with annual incomes below 55 percent of national poverty standards, but those with higher AFDC income standards would be required to continue use of the higher standards in determining Medicaid eligibility.

People with annual incomes in excess of twice the federal poverty level would be ineligible. Income eligibility would be determined over a 12-month period, rather than on a monthly basis.⁶

Benefits would be comprehensive--although less so than under certain current Medicaid programs--and to improve access to health-care services, reimbursements for physicians' services would be raised to the level of Medicare. States could continue to provide certain optional coverage, but with the federal government continuing to share the costs of these services.

Such uniform eligibility standards would increase Medicaid eligibility and costs substantially. If these standards had been in effect in 1980, about 7 million additional low-income persons would have been eligible; federal outlays would have been \$1.9 billion higher, and state expenditures would have been \$1.5 billion higher. About 5 million of the nonpoor--people with annual incomes in excess of twice poverty--would have been disqualified. By terminating eligibility for even more persons with relatively high incomes, adoption of uniform national eligibility standards based solely on income could be accomplished without raising expenditures.

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6. These eligibility criteria are similar to those included in the Carter Administration's Healthcare program. This proposal was one of the most extensive revisions of the low-income health coverage to have been considered by the Congress in recent years.

The Healthcare proposal had provisions that went beyond an expansion of Medicaid such as an expansion of Medicare and mandating employment-based coverage that would have provided protection against catastrophic illness. The discussion in this paper is focused upon a proposal for expanded health coverage for low-income persons and excludes employer-mandated health insurance.

The Healthcare proposal would have given the federal government responsibility for the financing and administration of Medicaid. Complete federalization of Medicaid is discussed in the final section of this chapter.

This option would increase Medicaid coverage of persons with incomes below the federal poverty levels from the present 50 percent to 72 percent. Most of the newly-eligible population would be people previously excluded from Medicaid by categorical rather than income requirements (see Chapter II). Members of two-parent families, now ineligible for Medicaid in some states, would account for 40 percent of those newly eligible, single persons for 38 percent, and childless couples for 9 percent. Since adult males are likely not to meet current categorical requirements, they would make up 32 percent of those newly eligible (compared to the current 6 percent); whereas children under 21 would make up 30 percent (compared to 65 percent). About 6.8 million persons with incomes below the federal poverty line would remain ineligible.

Persons with equal incomes would be treated in a more uniform manner under this proposal. In 1980, 23 states had income eligibility standards lower than 55 percent of the federal poverty standard, and 20 states did not grant Medicaid to two-parent families with unemployed parents--all of whom would be covered under this example. Nevertheless, some variation among states would remain.

Use of annual rather than monthly income in determining eligibility would improve the targeting of benefits toward those most in need of subsidized health care. This change would reduce the number of persons with relatively high annual incomes who qualify for Medicaid on a part-year basis. Targeting would be further improved by the termination of eligibility for all people with incomes in excess of twice the poverty level.

Medicaid's extensive benefit package (described in Chapter III) has led to suggestions for restricting some benefits and for eliminating others. Recipients might be required to pay a portion of the costs of services they receive. Such restrictions could reduce Medicaid expenditures or permit reallocation to fund benefits for low-income people who are currently ineligible.

COST SHARING

If states were required to impose nominal cost sharing on all Medicaid patients, both federal and state Medicaid costs would fall; recipients would curtail their use of services, and the program would pay less for each service rendered. States may now impose nominal cost sharing on all recipients for optional state-chosen services, such as prescription drugs, but federal law prohibits cost sharing for physicians' services and hospital care provided to AFDC or SSI recipients. If recipients were required to pay 5 percent of the cost of physicians' services and half the cost of the first day of an inpatient hospital stay, federal Medicaid expenditures would be reduced by about \$700 million in 1982 and by \$4.6 billion over the five-year period ending in 1986.

To date, when cost sharing has been applied to all medical care, use of medical services appears to have been discouraged. The most recent literature suggests that medical spending would fall by between 15 and 20 percent if persons now required to pay nothing were required to contribute 25 percent. Results from one study suggest that low income persons' response to "coinsurance" does not vary from that of the general population.¹ If cost sharing were imposed only on outpatients, however, costly substitution of inpatient for outpatient care could occur; at least one experiment has confirmed this effect.²

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1. Personal communication with Joseph Newhouse of the Rand Corporation.
 2. Jay Helms and others, "Copayments and Demand for Medical Care: The California Medicaid Experiment," The Bell Journal of Economics, Spring 1978, volume 9, no. 1, pages 192-208.

Although cost sharing might discourage the use of nonessential care, use of needed health care might also be curtailed. Faced with required cost sharing, Medicaid recipients might choose to forego care they need and make other purchases instead. In some instances, postponing medical care could ultimately result in higher treatment costs in the future, but the extent of the effect cannot be determined.

Cost sharing in Medicaid could result in higher charges to non-Medicaid patients. Providers who could not collect cost-sharing amounts from Medicaid patients could, for example, raise charges to other patients to cover the losses. In addition, providers might be less willing to treat Medicaid patients.

ELIMINATE CERTAIN BENEFITS

The potential for cost saving by terminating coverage of some services could be considerable. By withdrawing Medicaid funding for dental care, an optional service in 31 states, the federal government could save \$360 million in 1982 and \$2.3 billion by the end of 1986.

The health effects of cancelling certain benefits would vary. A patient who stopped using certain medication--for instance, a drug to control blood pressure--because Medicaid no longer covered it, could suffer adverse effects. On the other hand, the detrimental health effects that could result from the termination of dental care would be smaller. Elimination of dental services, or any similar optional benefit, would reduce some of the state-to-state variation in the extensiveness of benefits.

Elimination of at least one optional service could lead to greater Medicaid expenditures, because it is a substitute for a more costly mandatory service. Coverage for intermediate care facilities is an optional benefit that all states have elected to provide. It substitutes for the more expensive care of skilled nursing facilities, coverage of which is federally mandated. Care in intermediate care facilities accounts for 24 percent of all Medicaid expenditures and represents about 45 percent of all Medicaid spending for optional services.

If such care were eliminated for the mentally retarded only, however, federal outlays would be \$1.3 billion lower in 1982. Some analysts suggest that the rapid growth of expenditures for this service--from 2 percent of Medicaid costs in 1973 to more than 7 percent in 1978--reflects states' shifting these patients from state facilities, for which Medicaid funds are not available, to intermediate care facilities, for which Medicaid does pay.

CHAPTER VIII. ALTER REIMBURSEMENT POLICIES

Many states have already taken advantage of what options federal law allows for limiting reimbursements to providers of medical care; but federal policies or procedures have prohibited the use of some alternatives and slowed the implementation of others. Liberalizing guidelines governing states' reimbursement methods could achieve several objectives. It could permit states to trim Medicaid expenditures without limiting eligibility or benefits. Or it could permit states to reallocate Medicaid resources to direct benefits more specifically toward low-income people. Finally, physician reimbursements could be raised in order to expand access to services under Medicaid.

EXPAND COMPETITIVE BIDDING

At present, the use of competitive bidding in the purchase of certain supplies and services is limited by federal law to some types of durable medical equipment, such as hearing aids and eyeglasses. Removing this limitation could enable states to use bargaining power to buy more services and supplies at volume discount rates.¹ Federal Medicaid outlays could thus be reduced by some \$90 million in 1982 and by as much as \$600 over the 1982-1986 period.

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1. Several proposals of this type have been considered by the Congress in the past. The House version of the Omnibus Reconciliation Act of 1980 (H.R. 7765) included a provision that would have permitted states to purchase clinical laboratory services through competitive bidding, on a demonstration basis. The Senate bill (S. 2885) would have permitted very broad use of competitive bidding and contracting for medical services and supplies. Agreement could not be reached on this type of proposal, and it was not included in the Conference Report. The Carter Administration's fiscal year 1982 budget also contained a competitive bidding proposal.

An argument against greater use of competitive bidding is that bulk purchasing could restrict choices for Medicaid recipients. Already, however, the choice of the source for particular services or supplies--especially clinical laboratory services--is often made by physicians, not patients.

STOP REIMBURSING HOSPITALS ON THE BASIS OF "REASONABLE COST"

The "reasonable cost" method of setting reimbursement rates (detailed in Chapter III), which federal law requires unless approval of an alternative has been obtained, has kept Medicaid hospital reimbursements higher than they would be otherwise. With greater freedom to exercise discretion in this area, however, states could likely lower Medicaid hospital reimbursement rates. Even the 12 states that have obtained approval from HHS to use alternative reimbursement methods might use lower reimbursement levels if even greater discretion were permitted.

Eliminating required reasonable cost reimbursement of hospitals could enable states to act as prudent buyers of hospital care, perhaps by setting a maximum reimbursement level and letting hospitals decide whether or not to care for Medicaid patients. States might be able to set hospital reimbursement rates at levels below average costs but high enough to be acceptable to a sufficient number of hospitals to meet the needs of Medicaid patients. Also, if approval from HHS were no longer required, states could more easily include Medicaid reimbursement in state-wide hospital rate-setting programs.

Hospitals might respond in various ways. Some might choose not to treat Medicaid patients, which would deny some recipients access to care. Others might respond by continuing to accept Medicaid patients at the reduced Medicaid reimbursement rates but shift any unmet costs to charges paid by some patients and by commercial health insurance plans. Resistance of other payers to higher rates could limit hospitals' abilities to do this. Still other hospitals might take action to cut costs so that reduced Medicaid reimbursements would not adversely affect net hospital revenues. Cost reduction would be most likely in the context of a prospective reimbursement program affecting other purchasers of hospital care as well.

Lower hospital reimbursements could adversely affect the financial condition of some facilities, especially those hospitals serving many Medicaid patients. This would occur if these hospitals were unable to lower costs sufficiently and were also unable to recoup their losses from other patients. Urban public hospitals, in particular, many of which already face financial difficulties, could experience large increases in their unreimbursed expenses.

The potential savings of this option are highly uncertain because of the unpredictable response of other Medicaid agencies and of the hospitals within their jurisdiction. If states were successful in lowering Medicaid hospital reimbursement levels by 5 percent, however, savings to the federal government would be about \$250 million in 1982.

PERMIT STATES TO SELECT PROVIDERS ON THE BASIS OF COST

The freedom of choice provision that now guarantees Medicaid reimbursement for any qualified provider or service that a patient selects has contributed to keeping program expenditures at high levels. A curtailment of this provision, allowing state programs to limit participation to low cost providers only or to contract for medical services with a few providers, could help curb Medicaid expenditures. Besides enabling states to engage in competitive bidding, as described above, states could contract with a limited number of hospitals to care for Medicaid patients. In metropolitan areas, provision of hospital care on a contract basis could yield savings of \$50 million in 1982 and \$300 million by the end of 1986.

Advocates of this plan have noted that it has the potential for even greater savings, because it would permit basic changes in the way that care is provided to Medicaid recipients. For example, states could assign recipients to particular physicians, who would then assume primary medical responsibility. Such an arrangement could give physicians a financial incentive to avoid unnecessary hospitalization of Medicaid patients. In contrast, opportunities appear limited for greater reliance by state Medicaid programs on organized health care delivery plans, such as HMOs. At present, HMOs represent a relatively small portion of the medical care market.

Critics of limitation of selection of providers by recipients argue that limiting the choices available to Medicaid recipients could degrade the quality of their care. A separate medical care system of lower quality for low-income persons could also result. On the other hand, one can argue that, by limiting the number of providers permitted to participate in the program, states could better monitor the quality of the care that recipients receive; the attention of Medicaid administrators would simply be focused on fewer providers. Furthermore, specific quality standards could be included among the selection criteria.

RAISE PHYSICIAN REIMBURSEMENT LEVELS

A significant number of physicians--at present, one-quarter of all primary care physicians--now refuse to accept Medicaid patients because of low reimbursement rates. The portion that does not actively participate in the program is even larger. Requiring that states raise physician reimbursement rates to the levels used under Medicare could improve Medicaid patients' access to care appreciably, but federal outlays would increase significantly.

Medicaid expenditures could rise by as much as \$730 million in 1982 and by a total of \$1.9 billion by the end of 1986. The increase in costs would result from higher payment for services now being rendered, as well as from an increase in the amount of care for Medicaid patients--about two-thirds for higher reimbursement levels and about one-third for greater use of services. This estimate takes account of the fact that some offsetting savings would occur as care provided in physicians' offices substituted for some care now delivered in emergency rooms.²

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2. An Urban Institute study of physician participation in Medicaid shows that a 10 percent increase in per recipient revenues would increase by 3 percent the number of Medicaid patients treated by physicians. See Hadley, "Physician Participation in Medicaid."

Raising Medicaid fees could ultimately lead to higher charges to non-Medicaid patients.³ Critics of this proposal therefore consider it inflationary and contrary to the objective of containing health-care costs.

Because Medicaid reimbursement levels vary from state to state, the higher costs and greater use of services that could result from this option would not be experienced equally in all states. Indeed, a number of states already use Medicare reimbursement rates to determine Medicaid payments. Overall, the amount of variation among states would be reduced.

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3. See Jack Hadley and Robert Lee, "Toward a Physician Payment Policy: Evidence from the Economic Stabilization Program," Policy Sciences 10 (1978-79), pp. 105-120; and Frank Sloan, Janet Mitchell, and Jerry Cromwell, "Physician Participation in State Medicaid Programs," Journal of Human Resources Supplement 1978, pp. 211-245.

CHAPTER IX. MODIFY THE FEDERAL ROLE IN FINANCING MEDICAID

Modifications in the terms of federal support for Medicaid could be used to either reduce program expenditures or permit reallocation of health-care support for low-income persons. The allocation of federal resources could be changed by placing a limit on federal matching for state Medicaid expenditures. Alternatively, the formula could be modified, or it could be supplemented.

IMPOSE A CEILING ON THE AMOUNT OF FEDERAL MATCHING FUNDS AVAILABLE TO EACH STATE

To limit federal outlays and discourage Medicaid expenditures by states, the Administration has proposed an annual limit on federal Medicaid expenditures (S. 1291). The limit, or cap, would be adjusted each year for inflation. The federal government would continue to provide funding for each state's Medicaid program on a matching basis, except that no state would receive an amount that exceeded its assigned ceiling.¹ The limit would be set at \$100 million below the currently projected level of outlays for 1981. In 1982, the limit would be raised by 5 percent and, in following years, it would rise by the prior year's increase in the gross national product (GNP) deflator. Each state's share of the capped level of expenditures would be held constant at the 1981 level projected in November 1980. Because the ceiling would rise at a lower rate than is projected for federal outlays under current

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1. Although the example discussed here applies a cap to all Medicaid expenditures, a cap could be imposed on only some of the covered services, such as nursing home care. For example, Chairman James R. Jones of the House Budget Committee proposed a cap only on long-term care expenditures for inclusion in the first budget resolution for fiscal year 1982.

policies, adoption of the Administration's proposal would lower outlays by \$0.9 billion in 1982 and by \$8.3 billion by the end of 1986.²

As part of this plan, the Administration proposes to grant states increased flexibility to modify eligibility, benefits, and reimbursements under their Medicaid programs. States could use this discretion to cut costs by using many of the eligibility, benefit, and reimbursement options discussed in previous chapters and many others, though adoption of some options would depend upon approval by HHS.

If federal grants were capped, states would probably try to cut Medicaid costs; but two types of states would have difficulty accommodating the cap without reducing eligibility or benefits that are currently mandatory. Most states that have already taken cost-containment measures have already exhausted the alternatives to eligibility and benefit cuts. Also, states that have added few optional eligibility categories or benefits would have few new avenues to explore.

Some states could cut costs by trying to improve management, but the potential for additional savings in this area may not be great. Several states--notably California, Michigan, New York, and North Carolina--have already adopted numerous administrative improvements over the years, yet their program costs continue to rise rapidly. Operation of fraud and abuse units is already quite attractive to states: while the states pay only 10 percent of the cost of these units, they receive 25 to 50 percent of each dollar saved. Nevertheless, the units charged with detecting fraud and abuse do not appear to be self-supporting.³ Finally, states accounting for 98 percent of all Medicaid expenditures have either already developed or are actively planning Medicaid management information systems.

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2. Estimates of savings from a Medicaid cap are very sensitive to economic assumptions, particularly the rates of inflation and unemployment. This and other estimates were prepared on the basis of the assumptions adopted by Senate and House Conferees for the First Concurrent Resolution on the Budget - Fiscal Year 1982.
 3. General Accounting Office, Federal Funding for State Medicaid Fraud Control Units Still Needed (October 6, 1980).

A portion of the federal savings achieved by this proposal would probably result from shifts in costs to state governments and to the private sector. States' expenditures would increase to the extent that they chose to replace federal aid with state revenues. A portion of the federal savings could become costs to the private sector if physicians and hospitals continued to treat Medicaid patients at lower reimbursement levels but increased their charges to other patients to offset lost Medicaid revenues.

The choice of a base period for determining capped grant amounts has great consequences for each state, because as little as one-tenth of one percentage point difference in a state's share of expenditures represents \$17 million in federal funds in 1982. States that anticipated receipt of a smaller percentage of total federal Medicaid funds in 1981 than in prior years would likely find the cap more confining than states that expect to incur a higher percentage. For eight states, anticipated 1981 federal Medicaid expenditures represented a share of total federal Medicaid expenditures that exceeded by 10 percent or more their share of total federal Medicaid expenditures in the period 1976-1980. In two states, their share of Medicaid expenditures was more than 10 percent lower than their share in preceding years.

The use of the GNP deflator to adjust grants would be more restrictive for those states experiencing higher-than-average increases in Medicaid expenditures because of faster-than-average growth in the eligible population, a rapidly growing elderly population, or other factors affecting expenditures beyond state control.

How state-to-state variations in eligibility and benefits would be affected is difficult to gauge. The largest relative change in the cost of Medicaid, in comparison with other state programs, would occur in states in which the federal government now finances the largest portion of Medicaid program costs. Consequently, such states are the most likely ones to restrict eligibility and benefits in response to the cap. The likelihood of this response increases because some states with high matching rates (up to 75 percent) have relatively small tax bases. To the extent that states with the highest matching rates are now those with the most limited eligibility and benefits, a ceiling on federal Medicaid grants that led to reductions would tend to increase state-to-state variation.

LOWER THE MINIMUM FEDERAL SHARE OF STATE MEDICAID
EXPENDITURES FROM 50 TO 40 PERCENT

If the minimum federal share of program outlays were lowered from the current statutory minimum of 50 percent to 40 percent, the federal government could save \$700 million in 1982, and a total of \$5.9 billion by the end of 1986. If this option were implemented in 1982, 13 jurisdictions would have less than half their program costs covered by the federal government.⁴ The lower federal subsidy would probably lead some states to reduce program costs by restricting eligibility, benefits, or by cutting reimbursements. To the extent Medicaid expenditures are reduced in these states, reductions in federal outlays from the proposal would be even larger.

The states that would be affected by this option account for a large portion of total Medicaid expenditures.⁵ In fiscal year 1977, about one-third of all Medicaid expenditures were made in these states. Three in particular--California, Illinois, and Michigan--accounted for about one-quarter of all expenditures, in part because of the broad eligibility and range of services their Medicaid programs offer.

State differences in eligibility and benefits would be somewhat lessened by lowering the minimum federal share. California, Illinois, and Michigan would be particularly motivated to reduce costs by trimming their programs, which would bring their programs

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4. The Senate Finance Committee approved a reduction of the matching rate to 40 percent to comply with reconciliation instructions of the revised second budget resolution of 1981 (S. Con. Res. 9).
 5. For fiscal years 1982 through 1983, the states that would be affected are Alaska (40.00), California (41.79), Connecticut (40.81), Delaware (48.16), District of Columbia (40.00), Hawaii (48.29), Illinois (42.59), Maryland (47.95), Michigan (47.69), Nevada (40.00), New Jersey (43.74), Washington (46.82), and Wyoming (44.71). Numbers in parentheses are the federal percentages that would be applied to total state expenditures in determining each state's federal Medicaid grant, if the minimum were lowered to 40 percent.

closer to the national average. Some interstate differences would probably continue, however. For example, five of the affected states--Alaska, Delaware, Nevada, New Jersey, and Wyoming--do not now provide coverage for the medically needy, and reducing the federal share of Medicaid in these states would discourage future coverage of this group.

FEDERALIZE MEDICAID

The federal government, rather than the states, could assume all responsibility for both financing and administering Medicaid.⁶ Whether converting Medicaid into a strictly federal program would add or detract from efficiency and effectiveness is debatable. Observers have widely divergent views on whether the federal government or the states are best suited to run Medicaid. On the one hand, this option would permit the federal government to take full advantage of economies of scale in administration. Being fully at risk for changes in expenditures would present the federal government with greater incentive for efficiency. On the other hand, critics of this approach maintain that states are more sensitive to budgetary implications even though their Medicaid costs are subsidized. Further, state governments have 15 years of experience administering Medicaid; they may therefore be in a better position to experiment with alternative administrative approaches to find more efficient ones.

PROVIDE LUMP SUM GRANTS FOR STATE PROGRAM EXPANSIONS

The Congress could appropriate a fixed amount each year to provide lump sum grants to states that choose to expand the groups eligible for Medicaid.⁷ Under a recent proposal, the annual

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6. This approach has been included in past proposals that would otherwise have raised state expenditures by expansions of eligibility. An example is the Carter Administration's Healthcare proposal.
 7. A specific proposal embodying this approach was suggested by the staff of the Senate Finance Committee during the Committee's consideration of low-income health insurance options in the 96th Congress.

amount available for supplemental grants would be determined through the Congressional appropriations process. Each state that chose to expand eligibility would receive a grant equal to a portion of the total supplemental grant appropriation--the portion to be determined by the state's percentage of total Medicaid expenditures in the preceding year--provided the expansions the state adopted cost at least the amount of the grant.

States would find substantial incentives to expand the number of persons eligible for Medicaid, especially since there would be no categorical restrictions on the expansions and no requirement for additional expenditure of state funds. But three factors could limit the extent of their response: uncertainty regarding future funding; concern that the size of the grants to states might be less than the cost of some specific eligibility expansions; and the fact that states now with limited eligibility would receive relatively smaller grants.

Uncertainty about future levels of funding for these grants and about future Medicaid costs would probably limit the eligibility expansions some states would adopt. Because anticipated growth in the cost of providing Medicaid to new eligible groups might require the states either to provide additional funding or cut back on eligibility in future, some states might be reluctant to expand coverage. This reaction is most likely in states that have not chosen to expand coverage to all optional groups under the current, open-ended matching provisions.

A second reason to expect only limited eligibility expansion is that the cost of certain expansions might exceed the lump sum grant available to a particular state, even in the first year. For this reason, states might select eligibility expansions that would cost significantly less than the initial year's grant.

A final reason to anticipate limited eligibility expansions is that the size of the grants would be related to a state's past Medicaid expenditures. As a result, states that now cover only a small fraction of the poor would receive relatively small grants, offering little incentive to expand coverage, whereas states that had already expanded eligibility significantly beyond the minimum required level would receive the largest grants but have relatively fewer ineligible poor.

Within a given state, availability of a supplemental grant might increase the extent to which persons with comparable incomes would be eligible for Medicaid. By relaxing federal eligibility requirements and providing an incentive for increased eligibility, the proposal would encourage inclusion of people with low incomes who are now disqualified on a categorical basis. Among states, though, this proposal could either increase or decrease such variation. State-to-state variation could become more extreme, because the greatest incentives would be directed to states now with highest proportions of eligible poor. On the other hand, if the states that responded to the incentive were primarily those with limited current programs, interstate variation might decline.

APPENDIX I. ESTIMATION OF MEDICAID ELIGIBILITY

Estimates of the noninstitutional population that is eligible for Medicaid were obtained from a model of eligibility developed by Mathematica Policy Research, Inc. For a description of the microsimulation model and the estimation procedures, see Pat Doyle and others, Final Report: Creation of the 1980 and 1984 Data Bases from the March 1978 Current Population Survey, Volume 1. Mathematica Policy Research, Inc. CBO has made modifications in the model. Estimates produced by the model represent the number of persons who meet the eligibility criteria during a given full year or for any part of that year.

The population estimates used as the basis for the model were obtained from the Census Bureau's March 1978 Current Population Survey. These estimates were adjusted to reflect expected changes in population, employment, and income between calendar year 1977 and fiscal year 1980.

